Corporate (801)262-7475
Customer Service (800)662-5851
EMIHealth.com

Group: Nick M B Enterprises LLC dba Black Oil Field Services (Plan #9795)
Plan: PPO
Underwritten by: Companion Life Insurance Company
Administered by: Dental Management Administrators
Effective Date: 8/1/2024
Benefit Year: Contract
Plan Type: Voluntary / Fully Insured

	In-Network	Out-of-Network
Type 1 - Preventive Oral Exams, Cleanings, Bitewing X-rays, Fluoride	**100%**	**100% up to R&C***
Type 2 - Basic Fillings	**90%**	**80% up to R&C***
Type 3 - Major Crowns, Bridges, Prosthodontics	**60%**	**50% up to R&C***
Type 4 - Orthodontics	**50%**	**50%**
Adult Orthodontics	50%	50%
Sealants	Type 2 - Basic	Type 2 - Basic
Space Maintainers	Type 2 - Basic	Type 2 - Basic
Endodontics	Type 3 - Major	Type 3 - Major
Periodontics	Type 3 - Major	Type 3 - Major
Simple Extractions	Type 3 - Major	Type 3 - Major
Oral Surgery	Type 3 - Major	Type 3 - Major
Waiting periods		
Type 2 - Basic	None	
Type 3 - Major	None	
Type 4 - Orthodontics	12 Month Waiting Period	
Deductible	In and Out of Network Deductibles are Combined	
Per Person	$100.00	
	Lifetime	
Deductible Applies To	Type 1, Type 2 & Type 3	
Annual Maximum Per Person	$1,500.00	
Orthodontic Lifetime Maximum	$1,500.00	
Network / Reimbursement Schedule		R&C (90th)*
Monthly Rates		
Employee	$52.27	
Two Party	$92.33	
Family	$140.80	

Provisions / Limitations / Exclusions	
Exams (including Periodontal), Cleanings	2 exams, 4 cleanings per plan year
Fluoride	1 per plan year
Sealants	1 per tooth per 36 months, ages 6-16
Space Maintainers	Up to age 16
Bitewing X-Rays	1 per plan year
Periapical X-Rays	No frequency
Panoramic X-Ray	1 every 3 years
Impacted Teeth	Covered in Type 3 - Major
Anesthesia - (Limited to surgical procedures only)	Covered in Type 3 - Major
Implants / Implant Abutments	Over age 16, 1 per 10 years
Crowns, Pontics, Abutments, Onlays and Dentures	1 every 5 years per tooth
Fillings on the same surface	No frequency

* When using a non-participating provider, the insured is responsible for all fees in excess of the Reasonable and Customary Charges (R&C).

Read Your Policy Carefully-This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

GROUP DENTAL EMPLOYEE ENROLLMENT APPLICATION AND CHANGE REQUEST FORM
COMPANION LIFE INSURANCE COMPANY

Administered by:
TDA
2800 N 44th St, Suite 500, Phoenix, AZ 85008
Telephone Number: (888) 422-1995
Fax: (602) 266-1948][1]

Underwritten by:
Companion Life

EMPLOYER INFORMATION – to be completed by the Policyholder or Group Administrator
Requested Effective Date: / /
Employer Name: Nick M B Enterprises dba Black Oil Field Services
Group Number: 9795 Dept/Div Number:_____ Hours Worked per Week:____ Hire Date: / /

APPLICANT INFORMATION (PLEASE PRINT) – to be completed by the Employee/Enrollee			
Last Name (Include Jr., Sr., etc.)	First Name		M.I.
Street Address	Apt Number	City	State/Zip
Social Security Number	Home Telephone		Work Telephone
Male □ Female □	Date of Birth(MM-DD-YY) / /		

PLAN AND COVERAGE SELECTION

□ Employee [□ Employee + Spouse][2] [□ Employee + children][3] [□ Family][4]

DEPENDENT INFORMATION (please attach additional pages as needed)			**Do any of your Dependents have any other dental**
Spouse Name	□ Male □ Female	Date of Birth (MM-DD-YY) / /	□ Yes Name of Carrier □ No
Child Name	□ Male □ Female	Date of Birth (MM-DD-YY) / /	□ Yes Name of Carrier □ No
Child Name	□ Male □ Female	Date of Birth (MM-DD-YY) / /	□ Yes Name of Carrier □ No
Child Name	□ Male □ Female	Date of Birth (MM-DD-YY) / /	□ Yes Name of Carrier □ No
Child Name	□ Male □ Female	Date of Birth (MM-DD-YY) / /	□ Yes Name of Carrier □ No

DEPENDENTS: Eligible Dependents are determined by your employer's eligibility terms.

AUTHORIZATION FOR DEDUCTION

I elect the dental coverage selected for which I am eligible. If any contribution from me is necessary to pay part of the cost of insurance, I authorize my Employer to deduct the contribution from my wages.

Signature:_____ **Date:**_____

REFUSAL/WAIVER – Complete ONLY if you are declining coverage for yourself or any Dependent.

I decline coverage for: □ **Myself** □ **My Spouse** □ **My Children**

Signature:_____ **Date:**_____